STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING _____ B. WING _____	C 04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN RIDGE REHABILITATION CENTRE	**600 WASHINGTON AVE WABASH, IN 46992**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint #IN00126244. Investigation of Complaint #IN00126244-Unsubstantiated, due to lack of evidence. Survey dates: 4/17/13-4/18/13 Facility number: 000081 Provider number: 155162 AIM number: 100289570 Survey team: Shelley Reed, RN Census bed type: SNF/NF: 62 Total: 62 Census payor type: Medicare: 9 Medicaid: 38 Other: 15 Total: 62 Sample: 4 Autumn Ridge Rehabilitation Centre was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint #IN00126244. Quality Review 04/19/13 by Lisa McColly	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.